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ABSTRACT

Community mental health curriculum in schools of social work education is discussed. The contents are compiled from a series of empirical studies, interviews, and meetings with social work faculty and students, and from analyses of curriculum materials as part of a three-year study conducted by the Council on Social Work Education. Chapter 1 discusses the domain of the community mental health field, including the community mental health centers and center programs, the 1975 amendments, and implications for social work education. In Chapter 2 the curriculum study and its findings are summarized. Issues examined include: mental health concepts in the social work curriculum, teaching-learning patterns, class-field experiences, and alternative curriculum models and innovations. Specific curriculum innovations implemented at the following schools of social work are discussed in Chapter 3: University of Chicago, Simmons College, New York University, West Virginia University, University of Kentucky, Florida State University, and the University of Michigan. Recommendations for future directions of social work education are included. It is suggested that there is a need to delineate the boundaries between community mental health curriculum and the rest of the social work curriculum. It is also recommended that guidelines be developed regarding the selection of field practicum settings available to social work students. An extensive bibliography is provided, along with names of the members of the Advisory Committee to the Community Mental Health Curriculum Project and participating schools and faculty liaisons. (SF)

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Community Mental Health in the Social Work Curriculum

by Allen Rubin

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Preface

This volume is based on the findings of the Community Mental Health Curriculum Project, a three-year effort funded by the Social Work Education Branch of the National Institute of Mental Health and conducted by the Council on Social Work Education. Its purpose was to develop baseline data on community mental health curriculum at the MSW level in graduate social work education programs, and to promote further development of curriculum in this area.

Most curriculum data were provided by members of the faculty study groups in the 19 social work education programs that participated in the project. These groups, which consisted of about six faculty members per program, collected and interpreted a massive array of data, developed detailed reports of their curriculum, supplied exemplary teaching-learning materials, and contributed to the successive refinement of project findings. Appreciation is extended to all study group members and to the 776 faculty members and 80 students who responded to the curriculum survey.

Very special thanks go to the faculty liaisons to the project in each study group. The liaisons, who are identified with their respective programs in Appendix 2, displayed great dedication in the cumbersome task of coordinating the overall curriculum self-study in their programs.

Members of the Joint National Advisory Committee to the Council's Community Mental Health Projects provided expert input into the design of the project and development of findings and recommendations. Appendix 1 identifies the Advisory Committee. Ralph Garber, who was then Dean of the Graduate School of Social Work at Rutgers University and is now Dean of the Faculty of Social Work at the University of Toronto, chaired the Advisory Committee and

delivered the keynote address at the first national workshop of the project.

Gratitude also is expressed to the 33 social work education programs that were not selected for participation in the project, but whose deans and faculty supplied course syllabi and overviews of their community mental health curriculum. These materials were an important source of data for developing project findings and also provided references included in the bibliography for curriculum development.

Two consultants made major contributions to the project. Leonard Bloksberg, Boston University School of Social Work, helped to conceive of the project and formulate its faculty survey design. Arthur Katz, University of Kansas School of Social Welfare, served as consultant to the Council's Community Mental Health Practice-Education Project. In this capacity he also provided consultation to the Curriculum Project. Council staff members of the Practice-Education Project who assisted in the Curriculum Project were Raymond Brien, Mary Gay Harm, Carolyn Maas, and Patrick Moriarty. Ronald Costen helped staff the Curriculum Project for one year and played a major role in the curriculum survey. Carl Scott, Associate Executive Director of the Council, served as director of the Council's integrated Community Mental Health Projects.

Finally, very grateful acknowledgment is made to the Social Work Education Branch of the National Institute of Mental Health for the grant which made the Curriculum Project and this volume possible.

ALLEN RUBIN
Project Director

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Introduction

The community mental health field of practice relies heavily on the social work profession. Federally funded community mental health centers employ social workers in 33 percent of their center director positions[1] and 17.5 percent of their full-time patient care staff positions.[2] No other discipline accounts for as many staff in these positions.

The prominence of social work manpower in community mental health is reflected in the ubiquity of the mental health field in graduate social work education programs. In 1976, for example, 35.7 percent of all full-time, second-year master's degree students enrolled in graduate schools of social work took their field practicum in mental health facilities.[3] This represented a 73 percent increase since 1968.[4] More students now take their field practicum in mental health agencies than in any other setting.

Until now, however, there has been no systematic assessment of how different graduate schools of social work are educating students for community mental health practice. This has been a problem. In 1969 the Council on Social Work Education granted increased flexibility to graduate schools of social work to develop concentrations consistent with each school's objectives.[5] But greater flexibility increases uncertainty concerning the educational content included in given concentrations from school to school, and this is apparent in the community mental health concentrations. Ambiguity in this area stems in large part from the myriad definitions, approaches, and priorities that are possible under the community mental health rubric.[6]

For example, community mental health implies the delivery of direct clinical services to patient "casualties" as well as preventive interventions with broader forces in community systems that may promote or impede the well-being and overall quality of life in the

community. Although community mental health is often viewed primarily in terms of innovative social interventions, its domain also includes the provision of more established forms of psychiatric diagnosis, hospitalization, and long-term intensive psychotherapy to persons who need them. Some see community mental health largely as an attempt to offset psychiatric institutionalization.[7] At least one community mental health program, however, viewed its increased admission rate to a state hospital as a criterion of successful aftercare, since it was increasing appropriate service delivery to persons in need of the protective environment of the state hospital.[8]

Controversy abounds among community mental health proponents concerning appropriate roles for state hospitals. For some, they represent inhumane anachronisms that should be diminished through alternative care facilities in the community.[9] Others question the cost/benefit of large-scale alternative care programs and deplore back wards in the community where conditions are less humane than in state hospitals.[10]

Contrasting approaches within community mental health compete for scarce resources and often appear incompatible. There is disagreement concerning what proportions of resources should be allotted to prevention as opposed to treatment. Similarly, many disagree about whether client service should be psychotherapeutic or environmentally oriented. Since therapist-patient interactions tend to generate more income and more statistics for accountability, budgetary constraints may impede the delivery of desired environmental services. In addition, some see prevention as an unfortunate move away from client care, where the skills of the practitioner may be most applicable and most needed.[11] Yet, for others, it is precisely the preventive, indirect services that distinguish community mental health from other approaches.[12]

Programs and practitioners have many options regarding interventions and client populations, some of which they may find more attractive than others, but any of which can be called community mental health. In short, the term "community mental health" conveys different meanings to different people. It is a concoction of dual perspectives, competing priorities, and unresolved controversies. This complicates planning for education in community mental health.

Social work education in community mental health can have diverse connotations and alternative foci, ranging from preparing students for therapeutically oriented casework to preparing them to become mental health planners or social change agents. Therefore it is important to examine how different schools are actually implementing their community mental health curricula. This assessment can help identify aspects of community mental health that are emphasized among schools and the curricular areas that may need

additional development. It also may help practitioners in community mental health programs determine what practice roles are most appropriate for recent MSW graduates and what areas of in-service training are most needed.

This monograph attempts to clarify how different schools of social work are implementing community mental health curriculum. It is based on a three-year project conducted by the Council on Social Work Education and funded by the National Institute of Mental Health to describe and develop community mental health curriculum in graduate schools of social work in the United States. Its contents are drawn from a series of empirical studies, interviews, and meetings with social work faculty and students and from analyses of curriculum materials. It includes four chapters.

Chapter 1 describes the domain of community mental health, Chapter 2 presents the curriculum study and its findings, Chapter 3 illustrates some innovative approaches to community mental health curriculum utilized by schools that participated in the project, and the final chapter presents a summary and recommendations. In addition, there is a bibliography divided into major topics frequently found in course syllabi on community mental health.

This report intends to advance understanding of the nature of social work education in community mental health as it is actually being implemented throughout schools of social work across the United States. Due to the scope and complexity of this phenomenon, all pertinent curriculum aspects cannot be covered with the level of scientific rigor that is possible under conditions more amenable to methodological control. Nevertheless, the multiple sources of data examined and the successive elaboration and refinement of findings through many collaborative meetings with social work educators lead the author to believe that the findings accurately portray the more salient dimensions of community mental health curriculum in graduate schools of social work.

Once readers have considered these findings in light of their own experience, it is hoped that they will be better prepared to determine what social work education in community mental health presently entails, where it needs to be modified or developed, and what the unresolved issues are that require more research. In addition, this monograph attempts to provide materials and ideas useful to educators seeking to expand their own teaching in community mental health.

NOTES

1. National Institute of Mental Health, memorandum from Madeline P. Logee to Frank M. Ochberg, April 13, 1976. This memorandum supplied statistics from a survey on center director profile conducted by NIMH.

2. Carl A. Taube, *Staffing of Mental Health Facilities in the United States: 1974* (Rockville, Md.: National Institute of Mental Health, Division of Biometry and Epidemiology, 1976), p. 53.
3. This percentage was computed from a table in Ann W. Shyne and Robert G. Whitcomb, compilers, *Statistics on Social Work Education in the United States: 1976* (New York: Council on Social Work Education, 1977), p. 51. The 35.7% includes 17.5% in community mental health agencies and 18.2% in psychiatric services. The 630 students who had no field assignment were omitted from the computations.
4. Frank M. Loewenberg, *Statistics on Social Work Education: 1967* (New York: Council on Social Work Education, 1968), p. 33. The table on this page shows that 20.6% of full-time master's degree students in 1968 were placed in what was then labelled the "psychiatric" field of practice. Again, students without field assignments were omitted from the computations.
5. "Curriculum Policy for the Master's Degree Program in Graduate Schools of Social Work" (New York: Council on Social Work Education, 1969).
6. Some researchers have attempted to assess a community mental health ideology or orientation as if it were unidimensional. As discussed in this section, such an approach is questionable. See, for example, F. Baker and C. Schulberg, *The Community Mental Health Ideology Scale* (New York: Behavioral Publications, 1967).
7. See, for example, W. G. Smith and Donald W. Hart, "Community Mental Health: A Noble Failure?" *Hospital and Community Psychiatry,* Vol. 26 (September 1975), pp. 581-83.
8. Alan M. Kraft et al., "The Community Mental Health Program and the Longer Stay Patient," *Archives of General Psychiatry,* Vol. 16 (January 1967), pp. 64-70.
9. See, for example, Franklin D. Chu and Sharland Trotter, *The Madness Establishment* (New York: Grossman, 1974).
10. See, for example, R. Reich and L. Seigel, "The Chronically Mentally Ill Shuffle Into Oblivion," *Psychiatric Annals,* Vol. 3 (1973), pp. 35-55; S. A. Kirk and M. E. Therrien, "Community Mental Health Myths and the Fate of Former Hospitalized Patients," *Psychiatry,* Vol. 38 (August 1975), pp. 209-17; and M. Gittleman, "Coordinating Mental Health Systems: A National and International Perspective," *American Journal of Public Health,* Vol. 64 (1974), pp. 496-500.
11. A powerful argument to this effect can be found in Elaine Cumming, "Primary Prevention – More Cost than Benefit," *The Critical Issues of Community Mental Health,* ed. Harry Gottsfeld (New York: Behavioral Publications, 1972), pp. 161-74.
12. For a thoughtful analysis of this dual perspective and its implications for social work, see Arthur Katz, "The Duality of Focus for Social Work Practice in Community Mental Health," *Journal of Social Welfare,* Vol. 3 (Spring 1976), pp. 23-33.

Chapter I
The Community Mental Health Domain

Before examining social work education in community mental health, it is necessary to identify the domain of community mental health that is pertinent to social work. This is a complex task. There is no uniformly agreed upon definition of community mental health. The term has been used to refer to the emotional status of a population, social and institutional influences on that emotional status, and a social movement characterized by social action to impact upon those influences, as well as a network of mental health service delivery programs.[1]

In addition to federally designated community mental health centers, relevant programs may include psychiatric outpatient clinics (whose clientele may range from persons experiencing mild adjustment reactions to previously institutionalized persons with chronic social and psychological impairment), short-term and partial hospitalization programs in general hospitals, social and psychological agencies delivering therapeutic or guidance services to children and families, transitional residences, sheltered workshops, and mental health planning and coordinating agencies. Facilities for long-term psychiatric hospitalization also fall within the community mental health purview, since preventing rehospitalization and assuring continuity of care require the effective integration of these facilities with community-based services. In addition, numerous social programs more peripheral to community mental health services per se, can have a distinct bearing upon the mental health of a community.

Thus there are unclear boundaries between the broad mandate and orientation of community mental health facilities and the functions of other social agencies involved in delivering services, developing policy, or social action in such areas as alcoholism and drug abuse, crime and delinquency, mental retardation, public and child welfare, employment, housing, and education. In fact, taking the broadest view of mental health and the areas that can be related to it, the domain of community mental health conceivably could include anything that bears upon the quality of life. Thus some realistic limits are needed for the community mental health concept to be manageable. For if community mental health includes anything that can affect the emotional well-being of a population, then it is nothing but a meaningless rubric that can be applied to almost any activity concerned with the human condition.

Unfortunately, the scope of community mental health cannot be narrowed without some arbitrariness. However, this can be done with some rationality. We shall limit the focus of this study to those areas in the community mental health domain that have the greatest direct bearing upon the employment of social workers in community mental health facilities, namely, the federal Community Mental Health Centers Program.

THE COMMUNITY MENTAL HEALTH CENTERS PROGRAM[2]

Community mental health legislation grew out of widespread public and professional dissatisfaction with the mental health enterprise prior to the 1960s and from the development of new mental health service delivery approaches during and after World War II. Dissatisfaction with the existing mental health service delivery system centered on three basic inadequacies. First, increasing numbers of persons were being crowded into long-term custodial psychiatric institutions that were understaffed, where treatment was at best, minimal, and where patients underwent major social and psychological deterioration. Second, there was an increasing awareness of social class inequities in the delivery of mental health services. Persons from lower socioeconomic strata were being underserved, and when served, care often tended to be insufficient, perfunctory, and regressive. Third, it became clear that people in need of mental health services outnumbered the capacity of the professional mental health system to serve them. Moreover, most people who sought emotional help turned to community caregivers other than mental health professionals or agencies. Of those who did seek care from the professional mental health enterprise, only a small percentage received or remained for a full course of treatment.[3]

As dissatisfaction with these shortcomings was peaking, new approaches to deal with them emerged. The efficacy of short-term treatment near the site of trauma for acute psychiatric disorders was demonstrated during World War II. This led to the opening of many psychiatric units in general hospitals after the war. During the mid-1950s, psychotropic medications were introduced. These tranquilizers and related drugs enabled symptomatology to be managed successfully with less need for lengthy hospitalization. Meanwhile, orientations toward emotional impairment were rapidly expanding, with increasing recognition of socioenvironmental factors that might influence the onset, duration, treatment, and definition of mental illness. New models were more concerned with the interface between the person and the social system (a long-established model for social work). Thus the vanguard of the mental health field began forwarding services associated with such concepts as prevention, consultation, social networks, and crisis intervention. Psychobiological and psychodynamic models were still important, but were no longer considered sufficient.

It was against the above backdrop that the Joint Commission on Mental Illness and Mental Health, established by Congress in 1955, spent five years analyzing the resources for alleviating the problem of mental illness in the United States. Its final report, *Action for Mental Health,* provided the recommendations that stimulated the development of the Community Mental Health Centers Program.[4] In seeking to redress existing problems in caring for the chronically impaired, the commission recommended a reduction in the size of state hospitals to a maximum of 1,000 beds, and conversion of these hospitals into centers of long-term care for all chronic illnesses, not just mental illness. The commission also proposed greater utilization of community general hospitals for short-term hospitalization. To increase service delivery for more acute mental illness, it suggested that "a full-time mental health clinic be available to each 50,000 of population" and that these clinics offer consultation in addition to diagnostic and treatment services.[5]

The focus of the commission report was on providing comprehensive and locally accessible mental health services in each community. These services would offer short-term inpatient, outpatient, and aftercare treatment and consultation, while regional and statewide services would provide intermediate and long-term inpatient care. However, the commission recommended that major mental illness be seen as the core problem and that critical and prolonged mental breakdowns receive top priority from fully trained mental health professionals.

In 1963 President Kennedy proposed a federal Community Mental Health Centers Program which, in large part, reflected the

commission's recommendations. Later that year Congress passed the Community Mental Health Centers Act to provide federal grants for the construction of community mental health centers, and two years later extended the program to assist in the initial staffing of the centers. The intent of both these pieces of legislation was to assure the following attributes of the mental health service delivery system:

1. *Service accessibility*, including geographical proximity to where clients live; harmonious, nonthreatening design of physical facilities; and 24-hour-a-day, seven-day-a-week service availability.
2. *Comprehensiveness of care*, including a range of services that deals with all aspects and phases of the patient's disorder and that meets the needs of the entire community, regardless of diagnostic classification, age, or other demographic characteristics, or ability to pay for services.
3. *Continuity of care*, including the coordination and unification of all mental health services, and case management of individual patients throughout all phases, loci, and modalities of their disorder and care.

COMMUNITY MENTAL HEALTH CENTERS

To achieve the above three objectives, each community mental health center in the federal program serves a designated "catchment area" with a population of 75,000 to 200,000. The catchment area concept expresses the commitment to provide accessible services to an entire community in a comprehensive, coordinated fashion. It implies that centers assume responsibility for seeing that the mental health service delivery system in the community is adequately responsive to community needs. This means that centers should assess the needs extant in the community. It also implies that centers should be aware of the needs of special target populations within the community who may require the most services, such as children, the aged, the economically disadvantaged, minority groups, or groups with problems associated with substance abuse, sexuality, mental retardation, and others.

Initially, five essential services were required of all community mental health centers: inpatient care, outpatient care, partial hospitalization, emergency services, and community consultation and education. To be truly comprehensive, however, centers also were required to provide (and all centers were encouraged to provide) the following five services: specialized diagnostic programs, precare and aftercare services for state hospital patients, rehabilitation services

for discharged patients reentering the community, in-service training, and program research and evaluation.

These ten services operationalized the comprehensiveness of care concept. To implement the continuity of care concept, the federal program stipulated that centers develop mechanisms to monitor the flow of patients, staff, and records among all services and to assure that each patient is eligible for all services, that the same staff member follow a given patient in all services, and that each service have access to case records of its patients in other services. As mentioned above, service accessibility was furthered by the catchment area concept. Service accessibility also was enhanced by the wide range of services provided and the 24-hour-a-day availability of emergency services.

In addition to good, overall clinical practice, the community mental health center is rooted in the principles of public health. These principles are reflected in the center's comprehensive range of coordinated and accessible services, its broad populational focus, and its preventive services.

Prevention can occur on three levels: primary, secondary, and tertiary. Primary prevention refers to improving environmental conditions that are pathogenic and strengthening environmental conditions that are health-promoting for a population. The ultimate goal is a reduction in the incidence of mental illness. Secondary prevention involves large-scale, early casefinding, diagnosis, and referral and prompt treatment to reduce the duration of disability. Tertiary prevention includes large-scale rehabilitation of long-term mental impairment to restore adequate social functioning.[6]

These preventive concepts are implemented primarily through the center's community consultation and education services. The consultation-education program provides assistance and information to other community care-givers, such as teachers, clergy, and police. It is believed that this can help alter environmental conditions in ways conducive to primary prevention, facilitate secondary prevention through early identification of community residents in need of care, and promote tertiary prevention by mobilizing and supporting a social network that can provide emotional and concrete assistance to persons attempting to readjust to community living.

THE 1975 AMENDMENTS

In 1975 Congress enacted amendments to extend federal support of community mental health centers. This legislation explicitly reaffirmed the original intent of the Community Mental Health Centers Act of 1963. In so doing, it maintained federal support for

the programmatic components and guidelines described above. Without lessening its emphasis on good clinical practice or any other features of the earlier legislation, the 1975 amendments added several new stipulations that highlighted some existing deficiencies and expanded the services and guidelines required of federally funded community mental health centers.

Several of the new stipulations concerned issues of major import to social work and social work education. Specialized services in four problem areas were added to the list of services required of community mental health centers. These areas were: (1) children, (2) the elderly, (3) alcohol abuse, and (4) drug abuse (the latter two were not required if the Department of Health, Education, and Welfare determined that insufficient need existed in the catchment area or that other programs were meeting current needs).

The 1975 amendments also added provisions for strengthening efforts in two service areas already required of comprehensive community mental health centers: (1) consultation and education, and (2) precare and aftercare services for state hospital patients. Regarding consultation and education, the Congressional committee summary cited the need to provide permanent fiscal incentives for developing indirect services. This was in response to financial pressures for direct clinical services that result in a relative neglect of consultation and education.

> Support for consultation and education services beyond the period for which support is offered for general purposes has been included in the law . . . because it realizes that payment for such services is not generally available to the centers under third party reimbursement plans or other sources of financing, and because the services are an integral part of community mental health programs . . .[7]

Thus the amendments provided for continued federal funding of a center's consultation and education services beyond the time that federal funds are no longer supporting the direct services of that center. They also required each center to establish an identifiable administrative unit responsible for consultation and education services.

Concerning precare and aftercare for state hospital patients, the Congressional committee summary noted:

> The Committee is disturbed by the failure in many instances of CMHCs and state mental hospitals to better integrate their systems of care . . . preinstitutional screening of patients is a basic and essential element of any CMHC program. The Committee intends, through preinstitutional screening and the post-institutional referral requirements, to emphasize the role of the CMHC as an alternative to hospitalization, and to make it clear to the States that CMHCs are to provide aftercare when needed.[8]

Therefore the amendments required that centers provide pre-institutional screening; post-institutional referral and aftercare; and transitional, halfway-house services after discharge or in lieu of in-patient care.

Three remaining provisions of the 1975 legislation are relevant here. They concern program management, program evaluation, and cultural differences. Regarding program management, the Department of Health, Education, and Welfare is required to use up to 2 percent of its annual appropriations to provide technical assistance and training in program management to community mental health centers. "This provision is intended to increase the emphasis on, and the quality of, program management in CMHCs, an area in which various studies and testimony have described some deficiency in the program to date."[9]

Regarding program evaluation, the legislation requires that each center provide effective procedures for developing, compiling, evaluating, and reporting data on its service costs, utilization, availability, accessibility, acceptability, and impact on the mental health of catchment area residents. Centers must review these data in consultation with catchment area residents to assure that their services are being responsive to resident needs. Each center must allocate at least 2 percent of its previous year's operating costs for these purposes.

Regarding cultural differences, if a center "serves a population with a substantial proportion of limited English-speaking individuals," it must plan and provide services, "to the extent practicable, in the language and cultural context most appropriate to such individuals."[10] Moreover, it must assign a bilingual staff member to give guidance to such individuals and to other staff concerning cultural and linguistic sensitivities and differences.

IMPLICATIONS FOR SOCIAL WORK EDUCATION

The federal Community Mental Health Centers Program involves a wide range of content pertinent to social work education, its primary educational source for professional manpower. The intent and broad domain of the centers program show a heavy overlap with social work concepts, whether they are concerned with the principles of good overall clinical practice; knowledge and skills in various therapeutic modalities; or content about communities, minority groups, social problem areas, or social program administration and evaluation. In fact, almost any aspect of the social work curriculum can in some way be equated conceptually with community mental health content.

Most of the literature on social work education in community mental health has focused on what content *should be* included in the curriculum. The most notable work in this area has been done by the Southern Regional Education Board, which found extensive overlap between social work content and community mental health. It observed that "the overwhelming portion of what would be included in the curriculum to prepare a social worker for broad community mental health practice was basic social work practice."[11]

More recently, Baird surveyed social workers in different fields of practice and found that regardless of the field of practice in which they worked, they tended to be oriented to the same basic concepts and value-knowledge-practice culture that characterize the community mental health field. A mutuality of orientations between social work and community mental health was found just as strongly among social workers in other fields of practice as among those working in community mental health. Baird concluded that "however different the technical vocabularies of social work and community mental health may be, there is an inescapable and profound commonality in their ways of perceiving and thinking about their own worlds and their habits of thought and perception."[12] Relatedly, McPheeters noted that "many persons . . . feel that community mental health is just good overall social work practice . . . "[13]

Berg identified knowledge, skills, and values that should be available in the social work curriculum in order to prepare students for community mental health practice. His list was quite extensive. The *major* headings alone included: (1) *knowledge of:* sociocultural variations in behavior, sociological theory, community resources, research and evaluation methods, public health principles and techniques, economics, public administration, political science, adult learning and continuing education, public education and media resources, historical development of mental health services, principles and theories of consultation, human development, abnormal psychology, problems in living, interventive methods, and self-awareness; (2) *skills in:* interpersonal work, direct intervention, macro or indirect interventions, administration and planning, mental health consultation, adult instructional methods, gathering and using data, and organizational coordination; and (3) *belief in such values as:* cultural pluralism, self-determination, program evaluation, never labelling or stereotyping clients, and social work's code of ethics. The appropriateness of some of Berg's components can be debated. Nevertheless, his list illustrates the vast range of content that can be related to social work practice in community mental health and the great overlap that can exist between that range and the overall social work curriculum.[14]

Social work's mutuality with community mental health, while perhaps desirable in terms of preparing social work manpower for community mental health practice, nonetheless can complicate the process of developing or assessing social work curriculum in community mental health. The basic problem is "the perennial question of where community mental health ends and the broader field of social welfare begins."[15]

Therefore, one may ask, what distinguishes specific community mental health content in social work education from general social work content that happens to be related to community mental health? Difficulty in distinguishing community mental health content from the overall social work curriculum was observed by Bloksberg in the planning project that laid the groundwork for the Community Mental Health Curriculum Project to be reported on here. He observed:

> Individual faculty with few exceptions have difficulty in portraying their mental health training program in a clear, comprehensive way . . .
>
> . . . with the exception of two schools there was no class curriculum *requirements* which distinguished those students in the mental health training program from other students in that school.
>
> Some schools indicated that community mental health concepts were diffused . . . throughout all parts of the curriculum and were not specifically segregated into identifiable courses. The basic argument for having confidence that community mental health concepts were taught . . . was that many faculty came from community mental health or closely related settings and drew upon their own professional experience as a source of specific concepts to be taught.[16]

Hence this study was proposed to secure data from multiple sources in a number of schools and to subject these data to a collaborative series of successive elaborations and refinements involving faculty, students, curriculum materials, and other sources of data. The remaining chapters present this study and its outcomes.

NOTES

1. Samuel Finestone, *Community Mental Health Services in New York City* (New York: Center for New York City Affairs, New School for Social Research, 1973).
2. This review is based largely on Alan I. Levinson, "The Community Mental Health Centers Program," in *Handbook of Community Mental Health*, ed. Stuart E. Golann and Carl Eisdorfer (Englewood Cliffs, N. J.: Prentice Hall, 1972), pp. 687-98.

3. R. G. Hunt, "Age, Sex and Service Patterns in a Child Guidance Clinic," *Journal of Child Psychology and Psychiatry*, Vol. 2 (1961), pp. 185-92.
4. Joint Commission on Mental Illness and Health, *Action for Mental Health* (New York: Basic Books, 1961).
5. *Ibid.*, pp. 262-63.
6. Gerald Caplan, *Principles of Preventive Psychiatry* (New York: Basic Books, 1964).
7. *Community Mental Health Centers Amendments of 1975, Title III, Public Law 94-63: Section-by-Section Summary Highlighted with Extracts from the Legislative History* (Washington, D.C.: National Council of Community Mental Health Centers, 1975), p. 10.
8. *Ibid.*, p. 3.
9. *Ibid.*, p. 18.
10. *Ibid.*, p. 14.
11. *Community Mental Health in Social Work Education* (Atlanta, Ga.: Southern Regional Education Board, 1975), p. 2.
12. John C. Baird, "Social Workers' Orientations Toward Community Mental Health Concepts," *Community Mental Health Journal*, Vol. 12 (Fall 1976), pp. 275-85.
13. Harold L. McPheeters, "Implementation Issues," in *Community Mental Health in Social Work Education, op. cit.*, p. 88.
14. Lawrence Berg, "Knowledge, Skills and Values Essential to Social Work Practice in Community Mental Health," in *ibid.*, pp. 17-19.
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Chapter II
The Curriculum Study

BACKGROUND AND METHOD

The purpose of the curriculum study was to develop baseline data on community mental health training at the MSW level in graduate schools of social work in the United States. Four major questions were addressed:

1. What mental health concepts are included in the curriculum?
2. In what parts of the curriculum are these concepts included?
3. What teaching/learning patterns or class/field experiences are utilized to teach this content?
4. Can alternative community mental health educational models be identified, and if so, which of them appear to be most effective?

The study design was based upon successive approximations of curricula through multiple methods of inquiry. To begin with, each Council on Social Work Education accredited graduate school of social work in the United States received an open-ended questionnaire asking each to provide a preliminary overview of its community mental health curriculum. Fifty-two schools chose to participate in the project by completing this questionnaire and returning it to project staff, along with copies of their NIMH training grant proposals and any other relevant materials they had. The project's National Advisory Committee then selected 20 of these schools for

more intensive study. The committee attempted to achieve diversity and some representativeness in geographical location, size of school, target populations served, and specialization frameworks employed. The 20 selected schools were then visited by project staff to clarify mutual expectations. Nineteen agreed to participate, and each established a study group of approximately four to six faculty plus one faculty liaison to the project staff. Each group agreed to conduct a comprehensive self-study of its community mental health curriculum.

During the initial staff visits many faculty expressed considerable uncertainty about how to distinguish community mental health curriculum from the rest of the curriculum. One option was to allow each school to use its own frame of reference or definition of community mental health as a guide. After exploring the implications of this approach, faculty and project staff agreed that it was probably unworkable, since study groups would be unlikely to achieve consensus about this distinction.

Project staff first observed this problem in reviewing the preliminary materials from the 52 applicant schools. In most of their submissions, respondents could not distinguish the dimensions of the community mental health curriculum from their overall curriculum. Moreover, only 12 of the 52 schools identified curricular requirements in community mental health courses or field experiences. For the most part, community mental health curriculum appeared to be equated with student selections of mental health-related agencies for their field placements.

In response to this ambiguity, project staff decided that the optimal way to initiate the self-study phase was to design a comprehensive instructor survey that would provide a consistent frame of reference within and among schools regarding community mental health content. Three design principles were employed:

1. The use of highly structured instruments to avoid confusion over how to identify community mental health content.
2. Distinguishing where community mental health content areas are taught with a specific focus on community mental health, from where such content is taught within a general context.
3. Surveying instructors throughout the overall social work program. (Faculty indicated that community mental health content would be dispersed over all parts of the curriculum.)

The major exclusions from the survey were non-mental health courses taught by part-time instructors and field practica in settings outside of community mental health. In all, 747 instructors were sur-

veyed on 1,123 courses or field practica. Appropriately completed questionnaires were returned by 516 instructors on 776 courses and field practica (a 69 percent response rate). Once the survey data were processed, summary data were mailed to each faculty study group. These were in reference only to the given study group's own school and were in the form of computer printouts, summary tables based on computer printouts, and staff guidelines and initial impressions in analyzing the data for the given school.

The faculty study group examined and discussed the survey data for its school and reported its findings to project staff. Project staff then formulated tentative analyses that were later elaborated and refined through meetings with faculty study groups in each school, national workshops for faculty liaisons, National Advisory Committee meetings, and interviews with 80 second-year students about to graduate in 12 of the 19 schools.

None of these inquiries was viewed, by itself, as sufficient. Instead, the integration of all of the data bases through a qualitative, analytic process provided the major project findings. Any one source of data was viewed as imprecise and served mainly to provide a basis for further probing and analysis. While some of the findings can be reported in tables of statistics, most cannot. By and large the overall findings are reported as consensual interpretations of data from successive inquiries with multiple sources.

FINDINGS

Community Mental Health Content Included

Given the conceptual overlap between social work and community mental health, one might expect that a large amount of community mental health content would be dispersed throughout the MSW curricula. This was indeed evident in the instructor survey. With very few exceptions, each course and practicum reported regular, planned inclusion of some community mental health content areas, and most reported including many content areas. Almost every listed content area was covered repeatedly in each school.

Table 1 displays the frequency of inclusion of each content area with and without a specialized focus on the mental health or community mental health field of practice. Overall inclusion rates ranged from 8 percent of the surveyed courses and practica for content area 49 (community mental health consortia) to 60 percent for content area 38 (low-income populations). The overall mean inclusion rate per content area was 30.3 percent. This means that the "average" community mental health content area was reported to be regularly taught in 30.3 percent of the surveyed curriculum offerings.

TABLE 1

Courses or Practica That Reported Including Community Mental Health Content Areas With and Without an Exclusive Focus on Mental Health or Community Mental Health (N=776)

Content Area	With Exclusive MH or CMH Focus	Without Exclusive MH or CMH Focus	Total
1. Components of Comprehensive CMH Center	8% (64)	11% (87)	19% (151)
2. Inpatient Services	14% (106)	19% (152)	33% (258)
3. Outpatient Services	16% (124)	24% (182)	40% (306)
4. Partial Hospitalization	10% (74)	11% (84)	21% (158)
5. Emergency Services	10% (78)	16% (121)	26% (199)
6. Consultation/ Education	10% (78)	20% (156)	30% (234)
7. Diagnosis/ Assessment	17% (128)	28% (216)	45% (344)
8. Rehabilitation Services	8% (63)	19% (141)	27% (204)
9. Aftercare Services	10% (79)	17% (130)	27% (209)
10. Inservice Training	8% (62)	14% (110)	22% (172)
11. Research and Evaluation	6% (49)	24% (186)	30% (235)
12. Crisis Intervention	12% (95)	27% (208)	39% (303)
13. Medication Maintenance	9% (72)	9% (72)	18% (144)

Content Area	With Exclusive MH or CMH Focus	Without Exclusive MH or CMH Focus	Total
14. Primary Prevention	9% (72)	34% (262)	43% (334)
15. Secondary Prevention	9% (66)	23% (176)	32% (242)
16. Tertiary Prevention	8% (65)	15% (115)	23% (180)
17. Community Needs Assessment	9% (72)	26% (206)	35% (278)
18. Latent Caregivers	8% (61)	25% (194)	33% (255)
19. Alternatives to Hospitalization	10% (79)	22% (167)	32% (246)
20. Continuity of Care	11% (85)	20% (154)	31% (239)
21. Comprehensiveness of Care	10% (76)	18% (138)	28% (214)
22. Briefer Treatment	10% (79)	20% (158)	30% (237)
23. Outreach or Accessibility	9% (66)	25% (198)	34% (264)
24. Citizen Participation	7% (55)	22% (167)	29% (222)
25. Catchment Areas	9% (67)	13% (99)	22% (166)
26. Coordination of MH Services	10% (77)	17% (131)	27% (208)
27. Use of Paraprofessionals	9% (66)	22% (174)	31% (240)
28. Interdisciplinary Interventions	12% (92)	30% (227)	42% (319)
29. Labelling and Stigma	15% (114)	29% (225)	44% (339)

Content Area	With Exclusive MH or CMH Focus	Without Exclusive MH or CMH Focus	Total
30. Populations at Risk	6% (47)	14% (105)	20% (152)
31. Alcoholism	10% (79)	22% (167)	32% (246)
32. Aging	8% (59)	27% (209)	35% (268)
33. Children/ Adolescents	13% (99)	34% (259)	47% (358)
34. Crime and Delinquency	6% (47)	24% (188)	30% (235)
35. Drug Abuse	8% (61)	22% (167)	30% (228)
36. Ethnic Groups	9% (67)	37% (280)	46% (347)
37. Ill Physical Health	7% (53)	26% (195)	33% (248)
38. Low-Income Populations	11% (84)	39% (302)	50% (386)
39. Marital Problems	13% (103)	27% (208)	40% (311)
40. Mental Illness	19% (149)	29% (228)	48% (377)
41. Mental Retardation	7% (57)	16% (126)	23% (183)
42. Poverty	8% (63)	39% (297)	47% (360)
43. Racism	8% (64)	39% (302)	47% (366)
44. Rural Problems	3% (24)	13% (100)	16% (124)

Content Area	With Exclusive MH or CMH Focus	Without Exclusive MH or CMH Focus	Total
45. Sexual Problems	10% (75)	21% (160)	31% (235)
46. Suicide	11% (88)	15% (123)	26% (211)
47. Urban Problems	5% (41)	30% (233)	35% (274)
48. State Hospital/ CMHC Linkages	10% (78)	11% (81)	21% (159)
49. CMH Consortia	4% (31)	4% (28)	8% (59)
50. Epidemiology of Mental Illness	6% (50)	11% (83)	17% (133)
51. CMH Policy	9% (69)	12% (80)	21% (149)
52. Influence of Social Policy on CMH	7% (54)	19% (151)	26% (205)
53. History of CMH Policy	5% (41)	8% (62)	13% (103)
54. Organizational Influences on CMH Services	7% (55)	20% (154)	27% (209)
55. Links Between Health and CMH	7% (51)	15% (116)	22% (167)
56. CMH Financing	8% (59)	11% (84)	19% (143)
57. Legal or Ethical Issues in CMH	12% (92)	24% (190)	36% (282)
Mean	**9.1% (70.6)**	**21.2% (164.5)**	**30.3% (235.1)**

The curriculum components that reportedly included many community mental health content areas were dispersed throughout the overall social work curriculum and were not concentrated in any particular sequence. The included content areas were most frequently taught without an exclusive focus on the mental health or community mental health field of practice. For those content areas taught without the exclusive mental health or community mental health focus, the mean per content area inclusion rate was 21.2 percent. For the areas taught with the exclusive focus, the mean per content area inclusion rate was 9.1 percent.

Assuming that instructors really taught what they said they did, the above findings indicate that MSW curricula were replete with community mental health content. Most of the content usually was taught without an exclusive focus on mental health or community mental health, reflecting considerable overlap with general social work content. Some of the most frequently included content areas, such as low-income population, racism, poverty, and ethnic groups, pertained to social problems or target populations generic to social work. These content areas might have been taught in ways that were only tangentially related to community mental health. Nevertheless, in many courses generic social work content was taught with an exclusive focus on the mental health or community mental health field of practice.

For example, the 50 percent of courses or practica that taught about low-income populations may have been inflated regarding actual community mental health content. Nonetheless, 22 percent of these offerings (11 percent of all surveyed offerings) taught about low-income populations exclusively within a mental health context. Moreover, most of the listed content areas were strongly related to community mental health even when taught in a generic context. Examples of such areas include continuity of care, crisis intervention, levels of prevention, and consultation and education.

Respondents may have exaggerated the amount of community mental health content they taught. Some instructors may have believed or wished others to believe they taught more than they actually did. Reported inclusion percentages also may have been inflated due to sampling exclusions. If more non-community mental health offerings had been surveyed, the inclusion percentages per content area might have been lower, especially when taught with an exclusive mental health or community mental health focus. However, surveying these other offerings would have increased, not reduced, the absolute number of offerings per school that included community mental health content. Also, it would not have altered the fact that almost all of the listed community mental health content areas were

covered repeatedly in each school, often with a focus on mental health.

Moreover, the findings on high reported inclusion rates were corroborated in the information supplied by the faculty study groups. It was the clear consensus of study group members that each of the 57 listed community mental health content areas should be and were regularly included in classroom and field curricula. In fact, the members agreed that most of these content areas received considerable emphasis in the curriculum.

Methods and Levels of Intervention Emphasized

The above inclusion frequencies neither reflect the depth in which content was taught nor what was emphasized. Although study group members believed that many of the content areas were taught in considerable depth, they did not measure this systematically, and their responses did not yield any clear patterns regarding which content areas were taught in greater depth than others. Therefore, student interviews were conducted in 12 participating programs to ascertain what aspects of community mental health were being emphasized. (The other seven programs refused or were unable to arrange student interviews.)

The interviews were held in groups. Each session included a partially structured, probing discussion and completion of an open-ended, one-page form on which students listed in order of emphasis up to five community mental health content areas that were taught in the most depth throughout their educational experience in the given graduate program.

Students reported a wide range of content categories. A content analysis of the verbal and written responses yielded a pattern within and across the educational programs. In 11 of the 12 schools in which students were interviewed, the various content areas reported as having been taught in most depth were those that come under the rubric of clinical interventions. Common responses in this category were: in-depth casework; interviewing skills and counseling; and individual, group, or family psychotherapy. These clinical methods usually were reported to have been emphasized in the classroom as well as in field settings.

The second most emphasized category pertained to theory or knowledge that related to the above clinical interventions, such as personality theory, ego-psychology, psychopathology, and the life cycle. Other areas, such as systems theory, service delivery systems, crisis intervention, program planning, management, evaluation and community needs assessment were also taught, but in less depth. The dominant trend of the responses in most schools was in the direction of clinical knowledge.

Students in the one school which deviated from the above pattern most commonly reported such areas as community organization, administration and management, planning, grantsmanship, research and evaluation, and community needs assessment as being taught in the most depth. These areas characterized the major themes of the overall curriculum in this school, which did not have a separate mental health concentration and tried to deemphasize clinical approaches in general (due to its special geographic/populational focus on Appalachia).

Students in one program reported a conflict between the ecological emphasis in their social work practice courses and a psychoanalytic emphasis in their fieldwork settings. Many of them were heavily influenced by psychoanalytically oriented psychiatrists in their field agencies who repeatedly criticized them for emphasizing the social environment in their clinical work. Whenever students would do so, they were given negative feedback because they were being "superficial" and had failed to understand the "real" bases for their clients' problems, that is, their clients' deeper intrapsychic pathologies.

Thus students reported feeling a severe role strain which they attempted to resolve by deferring to the "wisdom" of the psychiatrists. In many cases students inaccurately perceived these psychiatrists to be their field supervisors. While students regretted not being able to apply a more ecological approach in the field, they nevertheless believed that the psychoanalytic approach was what they would be most prepared to apply in their community mental health practice.

This phenomenon was discussed with community mental health faculty from other programs in the project. They generally agreed that the role strain which the students experienced and the way they dealt with it was common in other social work training programs in community mental health as well. While most of these faculty members attached importance to psychodynamic and psychotherapeutic forms of mental health practice, they expressed dissatisfaction regarding their inability to achieve a more balanced perspective among their graduates – one which would include greater attention to the interface of emotional problems and environmental stress, community resources, and other related wide-ranging human problems of populations at risk and the systems which should serve them.

Target Populations Emphasized

The overall curriculum in most schools included separate courses on special target populations as well as considerable content on these populations dispersed throughout other courses. Commonly identified were such populations or social problem areas as drug

abuse, aging, children/adolescents, ethnic groups, ill physical health, low-income populations, poverty, racism, marital problems, sexual problems, mental retardation, suicide, and urban problems. Several schools located in regions with unique characteristics focused much of their curricula on the special needs of their particular area. For example, some schools emphasized rural problems and populations, while others concentrated on identified urban communities. Similarly, some schools were organized around particular minority groups.

Yet the ways in which these overall foci impacted upon community mental health curriculum was often unclear. For example, some schools with a strong minority group focus emphasized cross-cultural themes in the definition of mental health, but nevertheless emphasized more psychological forms of intervention in terms of what community mental health students were actually being prepared to do.

In a few schools, however, the socioenvironmental problems of particular target populations did get reflected in how students conceptualized community mental health practice. For example, in one school which focused on Appalachia, students learned that due to the dearth and fragmentation of resources in this area, appropriate community mental health interventions could include program development and utilizing other human service programs and natural social networks for providing emotional care.

The case of alternatives to hospitalization is particularly relevant here. Patients being discharged from state hospitals constitute a high-risk target population, which is a major priority in current community mental health policy and planning. However, material obtained from faculty and students indicated that little attention has as yet been given in most social work curricula to interventions with these discharged patients. Although social work education reflects a strong value orientation to the general policy of maintaining clients in community-based alternative care facilities, this was rarely channeled into specific knowledge and skill education for carrying out this policy.

Most students who reported having some field experience in this area tended to question the value of that experience. They felt that reintegrating discharged patients back into the community meant treating patients that other staff did not want to treat. A few even doubted the relevance of such work to mental health. Their views of community mental health practice were basically limited to psychotherapy; not helping people obtain resources for community survival. In large part, students preferred not working with deinstitutionalized patients, thus reflecting the predominant stance of mental health practitioners who have, over the years, tended to neglect chronic schizophrenics.[1]

Differentiating Social Work Roles in Community Mental Health Practice

Faculty study groups were asked whether and how graduates of their community mental health training programs should be and/or were being prepared to make a distinctive social work contribution to community mental health practice. Responses to this issue were nearly unanimous – within, as well as among schools. Faculty agreed that graduates should be and actually were being prepared to make unique professional contributions in the following interrelated areas:

1. A social systems approach that emphasizes the person-problem-situation configuration and the interface between psychological and social/environmental factors.
2. A multicausal approach to problem identification and the development of multiple interventive strategies on various levels (micro, mezzo, and macro). Emphasized in this regard were advocacy, community organization, evaluation, program development, and negotiating and coordinating service delivery networks (in addition to clinical interventions).
3. Special awareness of specific target populations, especially the economically disadvantaged and minority groups.

The faculty study group responses on differentiation tended to be in reference to the overall curriculum. Study group members pointed out that the basis for differentiating social work practice in community mental health was found mainly in the more general components of the social work curriculum. General social work education, not the more specialized community mental health curriculum, was seen as that which mainly prepares students to distinguish social work's *unique* contribution to community mental health practice. This was due to social work's basic conceptual mutuality with the community mental health field.

Alternative Approaches to Community Mental Health Curriculum

In light of the overlap between social work and community mental health, what does a school really mean when it refers to its community mental health curriculum? Is it a separate, identifiable entity? If so, what and where are its boundaries?

The answers to these questions varied from school to school. In most schools the community mental health curriculum was merely the general classroom curriculum plus field placements in mental health agencies (not always community mental health agencies, but usually part of the overall mental health service delivery system). This can be called the *diffuse* approach. In this approach, community

mental health related content was dispersed in general courses, and some specialized mental health electives were available. Most schools using the diffuse approach had no community mental health requirements for students in the community mental health training program. Others simply required field placement in a mental health facility. For the most part, these schools made little, if any, distinction between community mental health and general social work.

Several schools used the diffuse approach in order to avoid separating community mental health from the context of broader social problems, socioenvironmental interventions, or the total human service delivery system. Others did so simply because they wished to avoid limiting student foci to any one field of practice. However, in most cases the reasons for taking this approach were unstated.

A small group of schools went beyond the diffuse approach and had identifiable community mental health training programs with systematic requirements in the class as well as field. This can be called the *specific* approach. The requirements of the specific approach usually included about two mental health courses (often community mental health seminars) and always included field placement in a mental health agency.

The extent to which the specific and diffuse approaches actually differed in terms of input and outcome is uncertain. Schools using either approach agreed that fieldwork in a mental health setting was the primary means for specialized community mental health education. Although the specific approach requires such a setting, there is presently no evidence to indicate meaningful differences between the two approaches in terms of the numbers of students in such settings or in the kinds of mental health field settings being used. Faculty in both types of programs agreed that most students interested in community mental health were those who aspired to become psychotherapists. Moreover, most mental health field settings and field supervisors used in each type of program were portrayed as primarily interested in psychotherapeutic forms of treatment.

Overview of Findings

Regarding two of the questions posed earlier, "What mental health concepts are included in the curriculum?" and "In what parts of the curriculum are these concepts included?", the findings can be summarized simply as "almost everything and almost everywhere." The remaining two questions, which pertain to teaching-learning patterns, class-field experiences, and alternative curriculum models, are addressed more fully in Chapter III. The curriculum innovations described there show how some programs attempted to broaden the scope and improve the effectiveness of their community mental

health curriculum. Some of the programs tried to modify several of the curricular attributes identified in the above findings, namely: the nebulous boundaries between the community mental health curriculum and the remaining social work curriculum; the heavy emphasis on direct service delivery and clinical treatment; student aspirations and identifications associated with the practice of psychotherapy, not the field of community mental health; and disparities between the broader perspective of community mental health education programs and the narrower psychotherapeutic priorities of many field supervisors and their agencies.

However, not everyone viewed all of these as undesirable attributes of community mental health education. For example, some programs saw community mental health as inseparable from broader social welfare problems. Others pointed to the heavy emphasis on direct service and psychotherapeutic interventions in the service delivery patterns of community mental health centers. Nevertheless, some of these attributes are mentioned in the recommendations made by the National Advisory Committee to this project, which are presented in Chapter IV. But first the remaining findings, those on the variety of innovative approaches to community mental health curriculum, are presented in Chapter III.

NOTE

1. See for example, Gerard Hogarty, "The Plight of Schizophrenics in Modern Treatment Programs," *Hospital and Community Psychiatry*, Vol. 22 (July 1971), pp. 197-203.

Chapter III
Curriculum Innovations

In addition to *describing* community mental health curriculum, the Community Mental Health Curriculum Project sought to promote the *development* of this curriculum. Several schools participating in the project already had developed strong community mental health curricula before the project began. Others did so during the course of the project. This chapter illustrates some of the innovative efforts schools have undertaken in preparing students for community mental health practice. The first part of the chapter provides overviews of seven different community mental health curricula. These seven programs show a number of the variety of approaches that can be taken toward community mental health and toward more integrated learning in that field of practice. The second part of the chapter describes innovative fieldwork arrangements that several participating programs use in an attempt to improve the integration between classroom and field learning and between the objectives of the overall community mental health curriculum and the priorities of fieldwork agencies.

INNOVATIVE COMMUNITY MENTAL HEALTH CURRICULA: SEVEN ILLUSTRATIONS

University of Chicago – Generalist Practice in Community Mental Health[1]

The University of Chicago School of Social Service Administration has a community mental health concentration for second-year students that consists of a specific community mental health curriculum which is geographically separated from the rest of the school.

Evanston, Illinois, a "medium-sized city – inner suburb," was chosen as the site of the program since it provides a realistic scale and a complexity of problems, while being small enough to trace the interrelationships among the problems and components of the area and its service delivery network. The program is organized around the generalist model of practice, which emphasizes the problem to be solved rather than adherence to a given method. The program sees the community mental health practitioner as being in a "boundary position" among organizational systems in the community. Consequently, the traditional model of relating to an identified patient is often replaced by interactions with nonpsychiatric professionals, community residents and gatekeepers, and organizations. Thus the curriculum emphasizes that in addition to direct treatment, competence is needed in coordination, planning, consultation, education, and politics. The nature of the problem to be solved prescribes the levels of intervention and methods to be utilized. Students are encouraged to draw upon all social work methods, singly or in combination, according to the diverse problems of the client system. Problem solving or preventive efforts may focus on any or all levels (for example, intrapersonal, familial, socioenvironmental, or institutional).

One technique used to enhance the above approach involves assigning each student to contrasting field experiences across the network of agencies. This exposes students to different modes and levels of intervention, a wide range of professional roles, a variety of agency settings, and the interface of agency boundaries. However, students do have a primary placement where the majority of their time is spent in a single agency.

The concept of a unified student placement that enables students to be involved directly and vicariously in a broad range of experiences is facilitated through weekly unit meetings held in the field. These meetings provide an understanding of the overall service delivery network and an opportunity to exchange various field experiences. In addition, a community mental health seminar is held primarily for those students in the Evanston community mental health placement. This provides an overview of major problems and issues in mental health service delivery and exposure to a variety of approaches to care of the mentally ill. There also is a treatment seminar for the community mental health students, in which students and faculty present actual interventions in the field and where theoretical material from various levels and approaches is examined.

Underlying all of the facets of this program is the concept of concentrating students in a geographical "critical mass," which enhances mutual support among students, peer consultation, faculty

impact in class and field, and a view of total community need and the service delivery system.

Simmons College –
Social Casework in Community Mental Health

Social casework is the only method concentration offered at the Simmons College School of Social Work. Therefore the specific community mental health training program, which is a subspecialization, concentrates on social casework in community mental health. While the overall program is highly clinical and psychodynamic, the community mental health program attempts to emphasize a stronger orientation to environmental stress and interventions at various levels. Students are required to take a community mental health survey course and at least one of the following courses: "Law and Community Mental Health," "Basic Supervision," "Consultation and Collaboration," or "Educational Methods of Prevention." Also, all community mental health students are assigned for two years of fieldwork in one urban catchment area.

The course objectives are to prepare students for beginning competence in negotiating within the legal system on behalf of clients; client advocacy; supervision of paraprofessionals, BSWs, and other formal and informal caretakers; consultation; and program development for micro-level prevention, particularly small group programs of public mental health education. The overall program objective is to prepare students for direct practice in community mental health, with an emphasis on comprehensive service and continuity of care. Students are expected, when appropriate, to continue to work with their clients even if the clients move from the primary agency to others in the catchment area. If clients enter an agency where the student is not based, the student is expected to support the client within the context of the agency's service and collaborate closely with practitioners in that agency.

Students are assigned to a different primary agency in each year of the program and have additional supervised assignments in one or more of the other catchment area agencies. However, most of them follow at least two cases through both years of fieldwork. In order for students to develop a broad understanding of the diversity of mental health needs in the population, caseloads primarily include persons considered to be multiproblem or severely disturbed high-risk clients, particularly children, the elderly, the economically disadvantaged, Black and Hispanic minority groups, and recent Portuguese immigrants. Students also are encouraged to become involved in community projects with "grass roots" agencies, and fieldwork schedules are designed to permit time for small preventive programs for high-risk groups.

The program also attempts to assure the achievement of its fieldwork objectives by holding monthly group meetings between the program's training director and agency administrators. In addition, students and their supervisors meet regularly with the training director, and a bimonthly integrative seminar is held for the students.

New York University -
Mental Health Services to Urban Poor Minorities

Like Simmons, the New York University School of Social Work community mental health curriculum is structured around a high-risk target population in an urban catchment area. However, the NYU program takes a somewhat unique interventive approach, which is exemplified by its concept of "community clinicians." It describes its new community mental health project as follows:

> The New York University community mental health program is focused on delivery of mental health services to urban poor minorities in the South Bronx, an economically disadvantaged, primarily Black and Puerto Rican community. This high-risk population is particularly vulnerable to mental illness and in need of a network of support systems for reintegrating and maintaining the mentally ill in the community. The training program concentrates on three objectives:
>
> 1. To train social work students as Community Clinicians, the school will teach a substantial body of knowledge on practice, including the blending of clinical and community skills and the unique demands of this type of practice. The orientation of the community clinician will be geared to prevention, a focus on population groups, a social functioning perspective, and an understanding of the ecology of the community. Specifically, students will identify and analyze a variety of innovative social work techniques with emphasis on the development of network therapy and self-help groups. Acquisition of the necessary specialized assessment and intervention techniques will enable them to assume the catalyst/consultant role with informal support networks and the facilitator/advocate role with formal helping agencies and organizations.
> 2. Curriculum content related to reintegrating and maintaining the mentally ill in the community will be developed over the five-year period of the grant. Plans include the publication of a sourcebook of key readings and the development of a casebook using case materials prepared by students, field instructors, and project staff.
> 3. The third objective of the project is the development of stronger and more effective linkages with community mental health agencies as part of a continuing practice/education partnership. Stress will be placed on the identification of key roles, organizational issues, and environmental pressures in this severely deprived population.
>
> The curriculum of the New York University School of Social Work provides an excellent base for training students for practice in the field of

community mental health. A systems-oriented, integrated approach to practice is taught which encourages the development of broadly based competence and permits versatility in the choice and application of intervention method. Planning, organization, and provision of community services is a major content area along with direct service to individuals, families, and small groups. Specific substantive knowledge relevant to minority group problems and methods of working with minority groups in an urban setting are stressed.

In working toward the fulfillment of the project's objectives, the School will give primary attention to the provision of appropriate services to Blacks, Puerto Ricans, and other Hispanics (as ethnic groups), and to the elderly and to children (as underserved age groups). Moreover, the School conceives of its project as a pilot program that may be beneficially adapted to other schools of social work facing similar needs throughout the nation.[2]

West Virginia University –
Resource Development and Social Change in Appalachia[3]

In contrast to the urban programs above, the MSW program at the West Virginia University School of Social Work is designed around the social, economic, political, and cultural complexities of rural and semi-rural Appalachia. Consequently, it emphasizes the social causes of behavioral deviance and the underdeveloped and fragmented economic and social resources of this geographical area. The program regards orientations toward the psychopathology and psychotherapy of individuals as unsuitable in terms of regional manpower shortages and population characteristics. The program focuses instead on the prevention of emotional distress associated with every day problems of living.

Social change through reallocating community resources provides the major thrust, and direct service to individuals and small groups is geared to natural settings where major attention is given to the interface of the adaptive tasks of the life cycle and situational stresses and strains associated with regional social problems. The negative, victim-blaming implications of a "culture of poverty" approach are diminished through an appreciation of the unique cultural heritage and aesthetically inspiring geography of Appalachia.

Since the program sees community mental health problems as being inseparable from broader regional social problems, it has no specific community mental health concentration. However, students interested in community mental health may choose readings, term papers, or field assignments in community mental health. Class and field components emphasize the development of linkages between community mental health centers and other human service programs. Consequently, major attention is given to knowledge and skills in such areas as program and community development, social planning,

consultation, community organization, social action, proposal writing, human service trends (such as deinstitutionalization), outreach in rural communities, and research and evaluation.

The classroom curriculum reflects the above approach. All students are required to take courses in social policy, research, and practice courses that span the continuum from individual to group to community interventions. All students taking "Human Behavior and Social Environment I" cover content on Appalachia, poverty, and racism. An integrating seminar is offered that focuses on the interrelationships of the various components of generic practice. This program's environmental orientation also is reflected in the field assignments of students placed in community mental health centers.

Exemplary of field assignments are efforts to generate new resources in basic health services, low-cost housing, remedial reading programs in public schools, roads, water and sewage systems, transportation programs, preschool socialization programs, child abuse programs, and information and referral centers. Students whose field assignments include direct service provision are assigned clients with broad social-environmental problems such as in employment, child care, medical care, housing, or transportation. Thus students in direct practice learn an appreciation of the emotional impact of broader environmental problems and skills in linking other human service systems to community mental health programs.

Students interested in community mental health have block placements in community mental health centers in both their first and second years of training. During the first year, the field assignment is of a generalized nature, providing a broad view of the mental health center, its program components, related human service resources in the community, and direct interventive experiences with clients and their environments. The second-year placement provides students with opportunities to specialize in administration, community organization, health planning, or research.

The model for field placements is the agency-based learning center, in which the integration of classroom and field learning is promoted by classroom faculty spending a major portion of their time supervising students in the field and through use of a field manual that delineates the content to be covered. In addition, the school holds an all-day seminar once a month during the field placement semester for all students and field instructors in community mental health.

University of Kentucky –
Generalist Practice in Appalachia

Another MSW program geared to rural Appalachia is described by the University of Kentucky College of Social Professions, Gradu-

ate Social Work Program. In some contrast to the West Virginia approach, however, the hoped-for outcome at Kentucky is a generalist social worker who will be able to problem-solve in any service delivery area in which practice occurs. The main vehicle for the community mental health curriculum is a teaching-learning center staffed by full-time faculty members whose duties and privileges are the same as those of other faculty. A weekly teaching-learning seminar is conducted that focuses on the specific knowledge and skills needed to function in the mental health service delivery system.

Twenty-five percent of the students in the Graduate Social Work Program have been regularly placed in the Mental Health Teaching-Learning Center, which has always been oversubscribed. Because of limited resources, the college has limited the number of students who can enter this practicum. The interest in the teaching-learning center has been attributed to the fact that most of the clinical and preventive programs within Kentucky are offered by the community mental health centers.

The mental health content in the curriculum is provided first through the Practicum Seminar offered in the teaching-learning center. The seminar content in the first year of graduate study focuses on the Mental Health Delivery System. This includes the philosophy and scope of the community mental health program in Kentucky, hospital-based programs, state services, special programs, and the services delivered by the private sector. Specific attention is given to the relationship of the various components of the delivery system and the concept of continuity of care and linking of services.

The college is now considering introducing a formal concentration in health and mental health and expects that this concentration will be built on a generalist base. Students will be required to obtain through a practicum-linked seminar or elective courses, content on the philosophy and structure of services in community mental health. It is anticipated that students at the graduate level in community mental health will be exposed – through their electives and required courses – to content on program evaluation, leadership roles, community planning, and prevention, since these are components of the generalist base as the college teaches it.

Florida State University –
Administration and Program Evaluation in
Community Mental Health[4]

The Florida State University School of Social Work community mental health training program is unique in that it consists of two separate and specific community mental health concentrations: mental health administration, and program evaluation in mental health. The mental health administration concentration includes core

courses in administration, organizational behavior, evaluative research, policy analysis, and planning. Students also participate in a special seminar in mental health administration and a planning/administration practicum in the state office of the Florida Division of Mental Health.

To improve fieldwork experiences in this concentration, the faculty has developed ten simulation experiences in mental health management: (1) values and ethics, (2) handling conflict, (3) staff development, (4) financial analysis, (5) grievance, (6) maximizing agency survival, (7) board relationships, (8) halfway house management, (9) managing the community mental health center, and (10) managing large-scale institutions (state hospitals or state mental health programs).

The mental health program evaluation concentration includes specialized content in research methods, basic and advanced statistics, basic and specialized methodology courses, electronic data management, policy analysis, and organizational behavior. The practicum setting is in a comprehensive community mental health center where students are involved in such experiences as needs assessment studies, outcome studies, studies in standard setting and monitoring, and developing management information systems.

The above concentrations can be taken only in the second year of training. The program assumes that all of its students will have gained sufficient prior direct service knowledge and experience in their first-year course and fieldwork.

University of Michigan –
The Project Stimulates a New Curriculum Plan[5]

After participating in the Community Mental Health Curriculum Project being reported in this monograph, the faculty study group at the University of Michigan School of Social Work developed a plan for a new community mental health curriculum. This curriculum represents a shift from a diffuse approach without any separate, identifiable community mental health concentration, to a specific approach that offers such a concentration. The proposed curriculum was partially adopted for the academic year 1977-78.

The plan attempts to prepare each student for the planning and delivery of mental health services, with balanced attention to indirect as well as direct services. Students in the concentration are required to take specialized community mental health courses. Several of these give major attention to social epidemiology, high-risk populations, prevention, deinstitutionalization, community mental health management and program development, and interventions with community care-giving systems. The plan also identifies some informal curricular activities that may be used to help solidify student identi-

fication with the community mental health field of practice.

Since the proposed curriculum provides a comprehensive model for other schools that seek to expand or improve their community mental health curriculum, it is reproduced in its entirety below. In this proposal, "IP"" stands for the school's Interpersonal Practice Division, and "CAP" stands for its division in Community Practice, Administration, Social Policy, and Social Program Evaluation. The curriculum has been partially implemented in the IP Division, but its outcome is less certain for the CAP Division. This difference has been attributed to the latter's emphasis on methods that can be generalized to many fields of practice.

A COMMUNITY MENTAL HEALTH CURRICULUM

A Proposal
by

CMH Study Committee:
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Introduction

The purpose of this curriculum is to train social work students to participate in the assessment and modification of conditions which affect community mental health by intervening with individuals, families, groups, and community systems. Specifically, an educational program is envisioned that would equip a social worker to help create and maintain formal and informal systems which are supportive of effective living by community residents. Thus the social worker must be prepared to participate in both the planning and delivery of public mental health services in particular communities.

A major emphasis in the curriculum will be to define the role of a social worker in community mental health to include substantial responsibility for indirect as well as direct services. Accordingly, emphasis will be given to the development and implementation of programs whose main action is on the organizational and environmental events associated with mental health problems. Direct interventions will be emphasized as well. The problems associated with mental disorder, developmental disabilities, and substance abuse will be considered in terms of the opportunities available to provide individuals, families, groups, and communities with assistance

for these problems. Balanced attention to both direct and indirect interventions should have the effect of preparing students to create innovative, supportive networks as well as strengthen the existing ones.

Objectives

1. To recognize and selectively utilize existing knowledge to promote community mental health practice.
2. To acquire sufficient knowledge about sociopolitical processes at the agency, community, and larger societal levels, and recognize their implications for community mental health.
3. To acquire some of the skills necessary to effect change in various disabling conditions at the level of small and large systems.
4. To acquire some ability to prioritize goals and assess the resources available to intervene at various levels of the community mental health system, i.e., individuals, families, groups, organizations, and community systems.
5. To identify appropriate entry points for various community mental health interventions.
6. To attain skill in collaboration, consultation, and other patterns of exchange in order to strengthen the linkages between community mental health and other formal and informal systems of service.

Course Plan

In addition to general requirements for all students in HBSE, SWPS, Program Methods, and Practice Skill Instruction, students who elect to complete the recommended program will take courses in each of the three categories below:

1. Students following the recommended program are expected to take Mental Disorders and one of the other two HBSE courses in this category:

   a. Mental Disorders (replaces 614 Psychopathology) – This course would focus on the behavioral disorders often considered under the headings of schizophrenia, major depression, character disorder, and neurosis. The utility and dysfunctions of these classifications would be examined. Various conceptions of etiology and effective treat-

ment would be discussed, especially from the perspectives of social epidemiology, genetics, psychopharmacology, psychodynamics and behavior modification.

b. Developmental Disabilities – Developmental disabilities, including mental retardation, would be considered as major social problems. The magnitude and major forms of this problem would be considered from an epidemiologic perspective. Various conceptions of etiology would be discussed in relation to a range of preventative approaches. The implications for intervention, particularly cost effective and normalization approaches, would be discussed.

c. Substance Abuse – This course would consider the major problems associated with the problematic use of alcohol and other drugs. The extent and various manifestations of this problem would be considered. Various approaches aimed at understanding the etiology and creating more effective treatment approaches would be considered. A variety of implications for preventative and remedial services would be discussed.

2. Students electing to complete the recommended program would take the following SWPS course – Community Mental Health Policies and Programs (replaces 604 Mental Health Programs). This course would focus on the value premises, legislative actions, judicial decisions, funding patterns, and organizational arrangements influencing community mental health programs. Particular attention would be given to how these factors affect meeting the needs of various client groups and high-risk populations within the community. Such topics as deinstitutionalization, decentralization, prevention, and third-party payments would be discussed. An important focus would be the relationship between the general health system and the community mental health system. The issues identified would be discussed in the context of an exposition of basic community mental health programs.
3. Students electing to complete the program in community mental health would take two of the three program methods courses described below. IP stu-

dents in particular may be advised to take the course entitled "Program Development and Management in Community Mental Health."

a. Program Development and Management in Community Mental Health (Ad. elective) – This course examines the administrative tasks which must be performed, beginning with the program concept and extending through an evaluation of the effort. Particular attention would be given to assessment of the size and needs of the population to be served, acquisition of the necessary funding, establishment of a program structure, and the management of its operations. These tasks would be considered in conjunction with a range of residential, preventive, and personal care programs in community mental health.
b. Community Mental Health Alternatives to Institutionalization (an IP elective replacing 725 ST: CMH/Aftercare) – The focus of this course is on the development of intervention skills which are relevant to the accelerating trend of serving clients in the community. A central concern will be the social worker's role in creating conditions and providing services to ensure that the quality of life is indeed improved for this group of clientele. Opportunities will be provided to examine the nature of this group's relationships with the welfare, public health, and other supportive systems within the community. The skills to be emphasized are those which will facilitate integration of individuals within this client group to the community. Integration will be considered especially in the residential, occupational-educational, and social-recreational spheres of their lives.
c. Collaboration with Community Caregiving Systems (CO elective) – This course will focus on acquiring the skills necessary for facilitation of optimum patterns of collaboration and development, including consultation, with a variety of community caregiving systems. Attention will be given to several types of potential caregiving systems: informal neighborhood and functional community networks, self-help groups, health,

school, and occupational systems, as well as other systems with formal connections to the larger social welfare system (e.g., public welfare). The course would be aimed at developing skills in the various phases of the collaboration process such as entry, contract negotiation, change processes and evaluation.

Practice Skill Instruction

1. Eight hours of field instruction will be required in a mental health agency, or in an agency that has a formal service agreement with a mental health agency. This is intended to be compatible with the prevailing patterns of block and concurrent field instruction for CAP students. IP students would ordinarily be expected to take their community mental health placement in the second year.
2. One of the overriding ideas in this curriculum is the importance of field instruction. In community mental health, field instruction will be relied upon to expose students to a large set of experiences and to provide opportunities to develop and apply a wide variety of skills. For example, students will be expected to have experience with both direct and indirect services, and with various levels of intervention, i.e., individual, organizational, community, and regional. For these reasons it will be desirable for many students to have more extensive and varied experience in field instruction. Accordingly, where it is appropriate, students will be encouraged to elect a third day in the field or a block plan field placement.
3. Agencies in various regions will be encouraged by faculty to collaborate in providing an orientation to the community in which the agency is located. The faculty member's role would be to facilitate the planning and implementation of a program which pools the resources of the community and various agencies. The intent would be to promote an identification with the formal and informal network of services in a community, rather than an exclusive identification with a single agency.
4. The groups formed as a result of the orientation program described above would meet periodically

throughout the year to promote integration and understanding of the service network. A faculty member identified with the community mental health program would assume responsibility for planning these meetings.

Extracurricular Activities

1. Entry, socialization, and enrichment of the community mental health experience are important functions. Activities directed toward these ends, although they may lie outside of the formal curriculum, constitute an important part of the student's educational experience. Some beginning experience already accumulated along these lines tends to confirm this observation. At the entry level, identified faculty would be available to explain the educational opportunities, course recommendations, and career lines related to community mental health. Throughout the student's tenure in the program, he or she would be invited to participate in group meetings with both faculty and others identified with this field of practice. Another purpose of these occasional meetings would be to identify and describe educational opportunities available elsewhere in the university and community. Selective participation in regional and national meetings would also be encouraged.
2. Career guidance and job search assistance is another means to create an identity as a social worker with special competence in community mental health. It is also a way to increase the available pool of resources for the education of later cohorts of students interested in community mental health. Finally, it is one of the principal ways the school can be responsive to the NIMH policy to improve and increase the supply of professional personnel available for practice in community mental health. Beginning efforts in this direction have taken the form of meetings supplementary to the school-wide meetings on job search. Both this and the establishment of an informal bank of the names of persons and agencies likely to be useful to those planning a career in community mental health have been well received by students.

INNOVATIVE FIELDWORK ARRANGEMENTS

As was noted above, faculty and students identified fieldwork as the single-most important component of community mental health curriculum. In many schools it was the only component that could be linked clearly with the community mental health curriculum. It also was noted above that students and faculty often identified gaps between the broader objectives of community mental health curricula and the narrower approaches emphasized by many field supervisors and their agencies. Several schools, most of which have specific community mental health curricula, are taking steps to reduce these gaps. Listed below are nine arrangements which these schools tended to view as most useful in this endeavor.

1. *Structuring the community mental health field placement program around a specified target population and/or geographical area.* This arrangement is used primarily to orient students to the overall service delivery system in a given area and to provide experiences in intervening within or upon that system. It also is thought to sensitize students to multiple needs and intervention levels that transcend traditional models of psychotherapeutic treatment. Variations in regional characteristics and attendant service priorities have parallel variations in how this arrangement is structured. For example, rural programs may focus on a larger, regional area such as Appalachia and may be more oriented to the development of basic human resources. Urban programs may focus on a particular high-risk catchment area (such as the South Bronx in New York City) or on a small city. Nevertheless, the principle underlying each program is basically the same, in that each has a unified community mental health field program that is geared to the special characteristics and service priorities of its specified target area or population. In large part, participating faculty viewed the unified field arrangement as the foundation that enables or facilitates employing the remaining arrangements discussed below.

2. *Assigning each student to more than one type of community mental health facility and intervention level.* This arrangement is used by several programs in order to expose students to different methods and levels of intervention, a wide range of professional roles, a variety of agency settings, and the interface of agency boundaries. An important distinction here is that the multiple assignment occurs within the context of a given semester's field placement. In other words, the varied experiences occur simultaneously, as opposed to having a single placement one year and a different one the next year.

3. *Continuity of student-client relationships across agency boundaries.* This arrangement was identified in one program that felt

it had unique potential for fostering an appreciation of continuity of care. The arrangement has three basic features: (1) that students continue to work with some clients who have moved to a different agency within the catchment area, (2) that the above work implies direct or indirect support of the client and/or close collaboration with practitioners in the new agency, and (3) that students follow some cases through both years of fieldwork. In addition to promoting appreciation of continuity of care, this arrangement may help students better understand the service delivery network, interagency and interprofessional collaboration, comprehensiveness of services, skills in client advocacy, and the client/agency interface.

4. *Flexibility in fieldwork schedules.* Several programs purposely build in free time and flexible schedules in student fieldwork in order to enable and encourage students to engage in innovative activities, such as small preventive programs for special target populations.

5. *Selecting agencies that deal with high-risk populations in need of broad social interventions.* One way to avoid a deemphasis of socioenvironmental interventions in fieldwork is to select fieldwork agencies that serve populations in greatest need of such interventions. While this is no guarantee that these interventions will be highly valued by the selected agencies, it may nevertheless increase the likelihood that students will observe the need for them and perhaps discuss their observations with faculty or field supervisors.

6. *Requiring that student caseloads include many persons with multiple environmental problems from high-risk populations.* This arrangement and its rationale are basically the same as in number 5. In addition to students choosing agencies that serve persons in need of socioenvironmental interventions, their exposure to and appreciation of such interventions may be enhanced by assuring that their caseloads consist largely of such persons-at-risk. Programs also may be able to make this arrangement in agencies which serve fewer high-risk clients.

7. *Regularly scheduled meetings of students with field placements in community mental health agencies.* Regularly scheduled meetings enable community mental health students to exchange varied field experiences. This process is used primarily to broaden student perspectives regarding different levels and methods of intervention. It also may enhance student understanding of the overall service delivery network and community needs and may stimulate mutual support and peer consultation. In addition, these meetings provide community mental health training program directors an opportunity to improve the integration of classroom content with the community mental health experiences of students in field settings.

8. *Regularly scheduled meetings between the community mental health training program director and field supervisors.* This

process is used for a variety of educational and administrative objectives that are not unique to community mental health. However, the process may be particularly important in community mental health due to common discrepancies between the broader perspective of community mental health educational objectives and the tendency for many field supervisors and agencies to emphasize narrower psychotherapeutic approaches. In one of the participating programs, the educational director saw this process as essential – largely because field supervisors often are unaware of the program's broadened interventive objectives. Also, field supervisors may need some assistance and support in approaching these broadened objectives in the context of narrower agency foci.

9. *Fieldwork manuals.* Several programs emphasized the use of manuals written to delineate the content to be covered in the field (or in the overall community mental health curriculum). These field manuals may be developed by the community mental health curriculum director and/or in collaboration with other faculty, students, or field instructors. In addition to highlighting special community mental health content, manuals may include information on population characteristics and community needs as well as guidelines and expectations vis-à-vis fieldwork experiences. One function of these field manuals is to inform or remind instructors and students of those aspects of community mental health or expectations for field experiences that might otherwise receive insufficient emphasis in more narrowly oriented agencies.

NOTES

1. Mimeographed copies of the Community Mental Health Syllabus for this program are available upon request by writing to Joshua F. Cohen, University of Chicago, 969 East 60th St., Chicago, Illinois 60637, and requesting the "Program Material Handbook, Advanced Generalist Methods, Community Mental Health, 1977, Sixth Edition."
2. Personal communication to Allen Rubin from Carol Sturtz, New York University School of Social Work, October 1977.
3. For more information on this approach see Robert Porter, "A Social Change Approach to Community Mental Health" (Paper presented at the Council on Social Work Education Annual Program Meeting, Phoenix, 1977).
4. For more information about this program see Harris K. Goldstein, *Report on the First Three Years: Program Evaluation Training in Mental Health* (Tallahassee, Fla.: School of Social Work, Florida State University, 1977).
5. For more information about this program see Thomas J. Powell, "The Impact of an Enriched Program of Community Mental Health Education" (Paper presented at the Council on Social Work Education Faculty Workshop on Community Mental Health Curriculum, Chicago, September 30, 1977).

Chapter IV
Summary and Recommendations

SUMMARY

Social work education programs have become a prominent supplier of manpower to community mental health facilities. Yet there has been great uncertainty concerning what the different programs are teaching about community mental health. Some of this uncertainty can be attributed to the myriad components and numerous dualities within the community mental health rubric. Community mental health proponents can debate endlessly such issues as treatment versus prevention, environmental versus psychodynamic interventions, preferred roles for state hospitals, and the appropriateness of various priorities in consultation, social action, and accountability. Consequently, there is great latitude in the ways different schools can interpret and implement community mental health curriculum. Recognition of this led the Social Work Education Branch of the National Institute of Mental Health to finance a three-year project conducted by the Council on Social Work Education to develop baseline data on community mental health curriculum at the MSW level in graduate schools of social work and to promote further development of curriculum in this area.

The Community Mental Health Curriculum Project utilized a variety of methods to study and promote the development of community mental health curriculum. This report has focused on the study of this curriculum and its findings. The study utilized multiple methods of inquiry and multiple sources of data through a series

of collaborative, successive approximations focusing on four major questions:

1. What mental health concepts are included in the curriculum?
2. In what parts of the curriculum are these concepts included?
3. What teaching/learning patterns or class/field experiences are utilized to teach this content?
4. Can alternative community mental health educational models be identified, and if so, which ones appear to be most effective?

A major problem throughout the project involved the pervasive mutuality and overlap between community mental health concepts and overall social work concepts. This severely complicated the attempts to assess community mental health curriculum, since it clouded the determination of where community mental health ends and the broader field of social welfare begins. Many faculty could not distinguish the dimensions of their community mental health curriculum from their overall curriculum and had difficulty in describing these programs clearly and comprehensively. Even when the domain of community mental health was limited to the intent and key concepts of the federal community mental health centers program, a heavy overlap with the broader field of social work remained – one in which any or all aspects of social work curriculum could be related to community mental health concepts or to preparing students for possible practice in community mental health.

Data were collected on four fronts. First, most courses and community mental health field practica were surveyed regarding community mental health content being taught. Second, a project faculty study group in each school reviewed the survey data and added its consensual judgment on them. Third, project staff visited each school to elaborate and refine tentative findings through interviews with study group members and, where possible, with students about to graduate. Fourth, faculty workshops and National Advisory Committee meetings were held to further elaborate and refine project findings and assess their consensual validity. By the end of the project, most findings were in the form of qualitative, consensual interpretations.

The study revealed that content related to community mental health was dispersed throughout all areas of the social work curriculum. This appears to be a function of social work's conceptual mutuality with community mental health and reflects the difficulty in trying to separate community mental health from the broader field

of social welfare. However, much of this content was taught with an exclusive focus on the mental health or community mental health field of practice. Yet the frequency with which community mental health related content was included did not reveal what areas were being taught in greater depth, especially to those students preparing specifically for community mental health practice.

While all students were exposed to an extensive range of community mental health related content, in most schools, those identified as concentrating on community mental health tended to focus on knowledge and skills associated with clinical diagnosis and treatment methods in direct service delivery. This was due in part to field settings, where agency priority tended to be on direct clinical service of a highly psychotherapeutic nature. This emphasis gained additional momentum from the fact that many students entered community mental health concentrations with aspirations to become psychotherapists, and thus perceived their eventual employment marketability to be enhanced by proficiency in psychotherapy. Consequently, most students preparing for community mental health practice appeared to identify more strongly with the *practice* of psychotherapy than with the *field* of community mental health, with the latter seeming to represent little more than a future source of employment.

The above emphases applied to most observed schools, but were more evident in some than in others. For example, one school took an approach opposite to the psychotherapeutic one, focusing community mental health curriculum on the development of basic social welfare resources and institutional change in Appalachia, while regarding orientations toward psychopathology and psychotherapy as unsuitable in terms of regional manpower shortages and population characteristics. Another had a community mental health program organized around the generalist model of practice. Still another had specific community mental health concentrations in administration and program evaluation. In several other schools where the clinical emphasis in community mental health was dominant, there were elements in the federally funded community mental health training program that attempted to expand interventive approaches and increase student awareness regarding target populations at risk, service delivery systems, and other key overarching concepts in community mental health.

All participating schools had federally funded community mental health training programs, but in most of them the program merely consisted of the general classroom courses plus the availability of field placements in mental health agencies. This typified the diffuse approach, in which community mental health related content was dispersed in general courses and no community mental health courses

were required. In most schools using the diffuse approach, it was very difficult to distinguish the boundaries of community mental health curriculum from those of the overall program.

In contrast to the diffuse approach, a small group of schools used the specific approach, which had a separate, identifiable community mental health curriculum with systematic requirements in both class and field. These requirements often included two community mental health seminar courses and always included field placement in a mental health facility. Most specific as well as diffuse programs identified fieldwork as the most crucial component of the community mental health curriculum.

This report identified nine innovative field arrangements that observed schools felt were most useful in achieving the objectives of their community mental health training programs. In addition, overviews of seven community mental health programs were provided to illustrate the different approaches to community mental health curriculum that can be taken.

RECOMMENDATIONS

The National Advisory Committee to the project held a final meeting to review the findings of the curriculum study, determine whether the inferential processes used in analyzing findings were sound (that is, to assess the consensual validity of the findings), and to develop any recommendations warranted from project findings. After analyzing study methods, findings, and inferential processes, this multidisciplinary panel of experts in community mental health and social work education and practice agreed that the present report conforms with their observations and has good consensual validity. Having established this, the committee proceeded to develop recommendations for community mental health curriculum in graduate schools of social work.

The recommendations are as follows:

1. In considering the expansion of the orientation and practice base of community mental health curriculum, it is recommended that particular attention be given to the following areas:
   a. Prevention.
   b. Consultation and education.
   c. Continuity of care (especially regarding alternatives to hospitalization).
   d. Targetting service delivery (e.g., to underserved populations or regions).

e. Program administration and management.
f. Program evaluation, research, and accountability.
g. Program development.
h. Community mental health policy.

2. There is a need to explicate the boundaries between community mental health curriculum and the rest of the social work curriculum. This does not necessarily imply that the community mental health components should be separated from the rest of the curriculum, just that they need to be articulated more clearly. It is recommended that students concentrating in community mental health be required to take classroom and field experiences specifically in community mental health. This could be accomplished through different alternatives, such as establishing specific sections of core courses for students concentrating in community mental health. Various other arrangements, which would not necessarily reduce curriculum requirements in other areas, also could be developed.
3. Guidelines need to be developed regarding the selection of field practicum settings available to students concentrating in community mental health to ensure that the range of settings utilized sufficiently represents the broad base of community mental health practice and the intent of the community mental health education program in the social work curriculum.

In conclusion, it can be noted that the recommendation to articulate more clearly the boundaries between the community mental health curriculum and the rest of the social work curriculum emerged more in recognition of social work's strong conceptual mutuality with community mental health than of any perceived weaknesses. In large part, community mental health can be viewed as an application of social work knowledge and values to the mental health field. Almost any content in the social work curriculum can be pertinent to practice in community mental health. Difficulty in separating out the community mental health curriculum merely may reflect the fact that much of community mental health is, indeed, good social work practice.

Bibliography For Curriculum Development In Community Mental Health

This bibliography consists of references that should be useful to faculty in preparing courses on community mental health and as reading assignments for students taking those courses. The references are divided into 14 categories, which were selected primarily for two reasons: they reflect the topics that appeared most frequently in the community mental health course syllabi submitted by various social work education programs to project staff, and they have the greatest abundance of recent literature relevant to social work education in community mental health.

Three criteria guided the selection of specific references: (1) appearance in reading lists of existing social work courses on community mental health, (2) most current date of publication and pertinence to the given categories, and (3) expected utility for social work students.

Prior to developing this bibliography, consideration was given to reproducing exemplary syllabi on a variety of community mental health courses. This option was rejected due to the great amount of duplication of references among syllabi and the large number of pages of the syllabi. Also, the bulk of most of the syllabi consisted mainly of assigned readings grouped under topic headings. The following bibliography simply takes the most common topics (some of which can be separate course titles) and lists references for each topic.

Thus this bibliography can be viewed as a kind of master syllabus for community mental health courses. Faculty who are develop-

ing a community mental health seminar may simply wish to organize it around the content areas and readings that appear here. Or programs may choose to develop separate courses along the lines of a given topic and its reading list. In fact, taking as a whole the 19 schools that participated in the Community Mental Health Curriculum Project, at least one separate course was offered on each of these topics. For additional content areas, the reader may wish to reexamine Table 1 in Chapter 2 of the text.

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Appendix 1
Advisory Committee to the Community Mental Health Curriculum Project*

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Appendix 2
Participating Schools and Faculty Liaisons in the Community Mental Health Curriculum Project*

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University of West Virginia	Robert Porter
Wayne State University	Leon Lucas